



ROSE FAMILY Early Childhood Education Center
14200 Lamar Avenue • Overland Park, Kansas 66223 • www.bethshalomkc.org
School (913) 647-7285 • Synagogue (913) 647-7279 • Fax (913) 647-7278



EMERGENCY INFORMATION
(Please fill out as completely as possible)

TODAYS DATE: _____

CHILD'S NAME _____

DATE OF BIRTH _____ WEIGHT _____

HEBREW NAME _____

NICKNAME _____

NAME FOR CUBBIES _____

ALLERGIES _____

WHAT IS THE REACTION? _____

PARENT 1 NAME _____

PARENT 2 NAME _____

HEBREW NAME _____

HEBREW NAME _____

HOME ADDRESS _____

HOME ADDRESS _____

CELL PHONE _____

CELL PHONE _____

E-MAIL ADDRESS _____

E-MAIL ADDRESS _____

PLACE OF EMPLOYMENT _____

PLACE OF EMPLOYMENT _____

PHONE _____

PHONE _____

OCCUPATION/TITLE _____

OCCUPATION/TITLE _____

PEDIATRICIAN'S NAME _____

PHONE _____

ADDRESS _____

HOSPITAL PREFERENCE _____

IN CASE OF AN EMERGENCY (PARENTS WILL BE NOTIFIED FIRST), PLEASE LIST EMERGENCY CONTACTS WE CAN REACH BESIDE YOURSELVES (PLEASE CONTACT THE SCHOOL OFFICE IMMEDIATELY WITH ANY CHANGES):

1) _____ HOME PHONE _____

RELATIONSHIP _____

CELL PHONE # _____

2) _____ HOME PHONE _____

RELATIONSHIP _____

CELL PHONE # _____

3) _____ HOME PHONE _____

RELATIONSHIP _____

CELL PHONE # _____

INITIAL _____



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STUDENT INFORMATION SHEET

CHILD'S NAME _____

ARE THERE ANY PHYSICAL PROBLEMS OR LIMITATIONS WE SHOULD KNOW ABOUT? _____

DOES YOUR CHILD TAKE ANY MEDICATIONS REGULARLY? IF SO, PLEASE LIST THE NAME(S), THE DOSE, AND THE REASON FOR THE MEDICATION.

HAS YOUR CHILD HAD ANY SERIOUS ILLNESSES IN THE PAST? _____

PLEASE LIST CONTAGIOUS DISEASES AND DATES _____

HAS YOUR CHILD EVER BEEN HOSPITALIZED? WHEN? FOR HOW LONG? FOR WHAT? _____

BROTHERS AND SISTERS:

<u>NAME</u>	<u>BIRTHDATE</u>	<u>SCHOOL ATTENDING</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

WHAT WOULD YOU LIKE YOUR CHILD TO GET OUT OF THIS YEAR'S SCHOOL EXPERIENCE?

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S SCHOOL EXPERIENCE? _____

WHAT ARE YOUR CHILD'S FEARS? _____ HOW DOES HE/SHE REACT TO THEM? _____

HOW DO YOU COMFORT YOUR CHILD? _____

HOW DO YOU DISCIPLINE YOUR CHILD? _____

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S SPEECH AND LANGUAGE DEVELOPMENT? _____

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S MOTOR DEVELOPMENT? _____

HAS YOUR CHILD EVER HAD A SPEECH & LANGUAGE, MOTOR OR BEHAVIORAL EVALUATION? YES _____ NO _____

IF ANSWER IS YES, BY WHAT AGENCY AND DOES YOUR CHILD RECEIVE THERAPY? _____

IS THERE ANY INFORMATION THAT WE SHOULD HAVE TO BE MORE EFFECTIVE WITH YOUR CHILD? HOW CAN WE BE OF THE MOST HELP TO YOU? _____

ANY OTHER ADDITIONAL CONCERNS? _____



NEW STUDENT INFORMATION SHEET

Child's Name _____

Parents Names _____

Were there any concerns at birth?

When did your child first sit up? _____

When did your child first crawl? _____

When did your child first walk? _____

First Words? _____

What were they? _____

Does your child speak in complete sentences? _____

What language do you speak at home? _____

Other than Beth Shalom, are there any previous Nursery School, camp or day care experiences your child has had? If so, where and how long? Was it a positive experience?

Has your child been left with a baby sitter? ____ Yes ____ No. How often? _____

Anything special or concerns we should know about your child? _____



Toddler, Mini-School & 3's Questionnaire

Child's Name _____

Can your child have juice? _____ Yes _____ No

Do you dilute the juice? _____ Yes _____ No

Can your child have popcorn? _____ Yes _____ No

Can your child have raw carrots? _____ Yes _____ No

Can your child have raw celery? _____ Yes _____ No

Can your child have cucumbers? _____ Yes _____ No

We serve 2% milk with snacks. *If you would like your child to have something other than this, you will need to supply it.* Please let the teacher know.*

What raw fruits does your child eat? _____

What are your child's favorite foods? _____

Is your child toilet trained? _____ Yes _____ No

If not, are they in _____ Diapers _____ Pull-ups

Terminology used to express toileting needs _____

Does your child have a security item? _____ Yes _____ No

What is it? _____

What does your child call it? _____

Does your child use a _____ pacifier, _____ blanket, _____ stuffed animal?
Please make sure your child has this/these items at school during the day for security*.

Is there anything else you would like us to know? _____

Please update our staff or the director as this information changes.



AUTHORIZATION FOR EMERGENCY MEDICAL CARE

Written permission for emergency medical treatment must be on file at the facility. Consult with the local emergency medical facility to be sure this form is acceptable. Reference K.A.R. 28-4-127(b)(1)(A) except School Age Programs reference K.A.R. 28-4-582(e)(2)(B).

Name of facility exactly as stated on the license/certificate. <u>Beth Shalom Early Childhood Education Center</u>	License or Certificate # <u>005-7829-003</u>
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I hereby authorize Beth Shalom (Name of individual/staff member) and/or
Director / Staff (Name of individual/staff member) who is (are) representative(s) of the
above named facility to give consent for any and all necessary emergency medical care for my child or youth _____

(First and Last Name of Child or Youth) while said child or youth is in said facility's
custody between the dates of beginning of care and care terminated
MM/DD/YYYY MM/DD/YYYY

Signature of Parent or Guardian	Date Signed
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Witness to Parent's or Guardian's signature only if required by the local hospital or clinic.	Date Signed
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Notarization of Parent's or Guardian's signature

State of Kansas
County of _____
Signed or attested before me on _____ by _____
MM/DD/YYYY Name of Person
(Seal, if any.)

Signature of notarial officer

Title (and Rank)
My appointment expires: _____

Complete information regarding health care insurance, if applicable.

Health Insurance Policy Name: _____ Policy Number _____
Medical Assistance Program _____ Card Number _____
Military Medical Care I.D. Number _____

If known, date of last Tetanus inoculation: _____

List any known allergies or other information about the medical status of this child or youth pertinent in case of emergency:

THE MEDICAL RECORD/ASSESSMENT FORM (OR HEALTH STATUS HISTORY FORM FOR SCHOOL AGE PROGRAMS) AND THE AUTHORIZATION FOR EMERGENCY MEDICAL CARE MUST BE TAKEN TO THE EMERGENCY ROOM. BOTH FORMS MUST ALSO BE IN A VEHICLE WHEN THE CHILD OR YOUTH IS TRANSPORTED BY THE FACILITY.



**MEDICAL RECORD FOR ALL CHILDREN IN CHILD CARE FACILITIES,
INCLUDING PROVIDER'S OWN CHILDREN**

Parents are to complete the Medical Record and the History of Immunizations for each child in licensed child care facilities. The Medical Record, History of Immunizations, and Child Health Assessment are transferable when the child moves to another licensed child care facility.

Child's First Day in Child Care _____ Name of Child Care Facility _____

Child's Name _____ Date of Birth _____ Gender _____
First Last MM/DD/YYYY M/F

Parent/Guardian Information

Parent/Guardian Information

Name _____ Name _____

Home Address _____ Home Address _____
Street City Zip Code Street City Zip Code

Home Phone Number _____ Home Phone Number _____

Work Address _____ Work Address _____
Street City Zip Code Street City Zip Code

Work Phone Number _____ Work Phone Number _____

Cell Phone Number _____ Cell Phone Number _____

E-mail Address _____ E-mail Address _____

Best way to contact _____ Best way to contact _____

Names and ages of children in family _____

Persons authorized to pick up the child or to notify in case of emergency. Include name, address, and telephone number. Attach an additional page, if necessary. _____

Child's Physician _____ Phone Number _____

Child's Dentist _____ Phone Number _____

Hospital Preference (for emergencies) _____

Has your physician approved the use of any non-prescription medications for your child such as acetaminophen, cough syrup, or ointments that can be given by the child care provider? ___No ___Yes, as follows:

Does your child have any of the following conditions (yes or no)? If yes, provide information on Authorization for Emergency Medical Care form CCL. 010.

- | | | |
|-------------------------|-----------------------------------|-----------------|
| _____ Allergies | _____ Frequent sore throats/colds | _____ Ear Aches |
| _____ Asthma | _____ Speech, Visual, Hearing | _____ Diabetes |
| _____ Epilepsy/Seizures | _____ Other _____ | |

If yes answered to any above, please provide additional information _____

Have there been major changes at home that might affect your child in care? ___No ___Yes, as follows:

Please provide additional information or special instructions that will help the person caring for your child.

Parent/Guardian Signature: _____ **Date:** _____

History of Immunizations

Required for all children in child care facilities, including the provider's own children. A Kansas Certificate of Immunizations (KCI) may be substituted for this form and attached to the completed Medical Record.

Child's Name: _____ Date of Birth: _____
First Last MM/DD/YYYY

Section I. For a recommended schedule of immunizations, refer to the current schedule published by the Advisory Committee on Immunization Practices (ACIP).

Vaccine	Record the Month, Day and Year that each Dose of Vaccine was Received					
	1 st	2 nd	3 rd	4 th	5 th	6 th
DTaP/DT/Td/Tdap (Diphtheria, Tetanus, Pertussis)						
Polio						
MMR (Measles, Mumps, and Rubella combined)						
HBV (Hepatitis B Vaccine)						
Varicella (Chicken Pox)			Hx of Disease: Physician Signature		Date of Illness:	
HIB (Hemophilus Influenzae Type B)						
PCV7 (Pneumococcal Conjugate)						
HEP A (Hepatitis A)						
Rotavirus **Recommended <8 mo of age; not required						
Influenza(Flu) ** Recommended annually >6 mo of age; not required						

Section II.

Complete this section only if your child is exempted from the law requiring immunizations [K.S.A. 65-508(d)].

The following two options are the **ONLY** exemptions allowed by law. **Please check either (A) or (B) below and complete as required:**

(A) Certification from licensed physician stating that immunization would endanger child's life:
 Exempt from following immunizations:

DTP Pertussis Only Tetanus Polio MMR Rubella Only Hep A Hep B
 Hib PCV7 Other

Physician's Signature (required): _____ **Date:** _____

(B) My child is exempt under the law from immunizations. As the Parent or Legal Guardian, I state that I am an adherent of a religious denomination whose teachings are opposed to immunizations.

Section III.

Parent/Guardian Signature: _____ **Date:** _____



PARENTAL PERMISSION FORM FOR OFF-PREMISES TRIPS

Name of the Facility (exactly as stated on the license)			License #	
Beth Shalom Early Childhood Center			0057829-012	
Street Address of the Facility		City	Zip Code	County
14200 Lamar Ave.		Overland Park	66223	Johnson

_____ may go to the following locations off the premises with adult supervision:

First and Last Name of Child or Youth

Place	Street Address	City	By Vehicle	Walk/Bike
Goldsmith Hall	14200 Lamar Ave.	O.P.		<input checked="" type="checkbox"/>
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Downstairs Library	14200 Lamar Ave.	O.P.		<input checked="" type="checkbox"/>
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Playroom	14200 Lamar Ave	O.P.		<input checked="" type="checkbox"/>
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	



Over The Counter Medication Permission Form

We, _____,
(names of parents)

give permission to the Nursery School administration and staff to administer the following OTC medications to our child, _____ as deemed necessary by the Director or her assistant. The staff will attempt to call for your approval.

Child's Weight: _____

_____ Children's Tylenol _____ Dosage
(Acetaminophen)

_____ Benadryl _____ Dosage

_____ Children's Advil (Ibuprofen) _____ Dosage

_____ Calamine Lotion

_____ Sunscreen

Signature

Date



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PICK UP AUTHORIZATION 2020-21

No child will be turned over to an adult other than a parent unless we have written authorization from you. Please complete the following authorization, affix your signature and return it to the school as soon as possible. Please make sure this is updated as your arrangements change.

My child _____ is to go home **ONLY** with the following family members, friends or other care givers: Please provide cell phone numbers below.

_____	Cell Number _____	Relationship _____
_____	Cell Number _____	Relationship _____
_____	Cell Number _____	Relationship _____
_____	Cell Number _____	Relationship _____
_____	Cell Number _____	Relationship _____
_____	Cell Number _____	Relationship _____

ADDITIONAL COMMENTS:

 (Parent's Signature) (Date)

****Remember: Please send a note if anyone other than your carpool will be taking your child home****

PLEASE CONTACT THE SCHOOL OFFICE IMMEDIATELY IF THERE IS ANY CHANGE IN CARPOOL AUTHORIZATION.

Payment Options Plan

METHOD OF PAYMENT - Please check one

One Payment - Paid in full by August 15, 2020

Two Payments - 50% due by August 15, 2020 and the balance by December 15, 2020

Check or

Credit Card Payment - Processed 15th of every month or next business day
Visa, Mastercard or Discover

▪ **MAXIMUM of two payments per year will be accepted.**

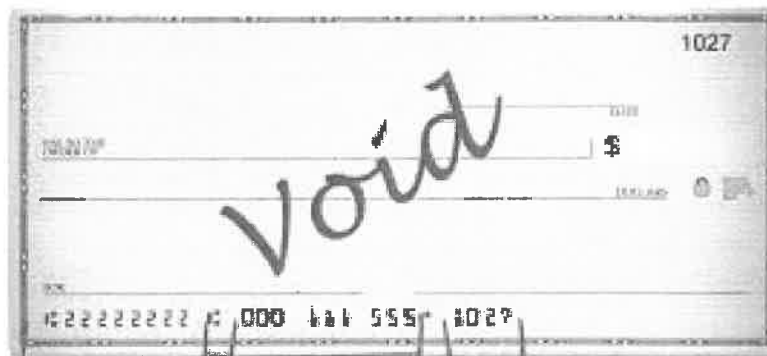
Credit Card # _____ Expiration Date _____ CVC _____

Nine Payments – 1/9 due every month, August 2019 through April 2020

Automatic Bank Transfer (ABT) - Processed 20th of each month, or next business day

▪ Automatically withdrawn from checking or savings account

Please provide a VOIDED check that shows your bank routing and account number.



Routing
Number

Account Number

Check
Number

Printed Name _____

Signature _____ Date _____